Employee Waiver Form

Employer Name: _____

Printed Name (first & last): _____

Date of Birth: _____

Last 4 Digits of SSN: _____

- ○ I decline coverage for myself
- ○ I decline coverage for myself and my dependents

Reason for declining coverage:

- ○ Other group coverage (spouse's/domestic partner's/parent's plan)
- ○ Medicare
- ○ Medical Assistance, TRICARE
- ○ No other coverage
- ○ Other *(Please explain):* _____

_____

I acknowledge I have been given the opportunity to enroll in group medical coverage provided by my employer. However, I am electing not to enroll. By declining this group health coverage, I acknowledge that I and my dependents (if any), may have to wait until the plan's next open enrollment period to enroll for group health coverage.

_____

Employee Signature

_____

Date

SUBMIT COMPLETED FORM TO:
Gravie Administrative Services, LLC
PO Box 3465, Minneapolis, MN 55403

SECURE FAX: 612.547.7240
SECURE UPLOAD VIA GRAVIE ACCOUNT